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Professor Walter Holland CBE in interview with Dr Michael Ashley-Miller
Oxford, 3 December 1996, Interview III

MAM Professor Holland, we've taken you through your career and your twenty-odd years at St Thomas', but I don't want to stop with your retirement from the chair because I think we ought to have a P.S. if you like, a postscript of some of the things that either you've carried on or are new in retirement. I don't think it would be a surprise to anyone in your career that you have not retired to hibernate, but have kept fairly busy. I wonder first if I could ask you, have you been seconded... We obviously accept that people I am sure have gone on writing to you and sought your advice, but have you been asked to go on any new specialist committees, government or otherwise?

WH I, I suppose the, I suppose there are two or three. The first one is the working party on cot deaths. As you know, there has been concern about the emission of gases from cot mattresses through contamination by certain bacteria which was publicised by a television documentary and has caused a great deal of concern. And I was invited to go on this as a completely independent epidemiologist to advise on that.

MAM This is government?

WH This is government, yes, a Department of Health committee. The second one – I've taken on...

MAM Can we just start... Is that, is that ongoing and have you got to any conclusions?

WH I'm sorry, I evaded it rapidly because it is still ongoing, and I'm sworn to secrecy at this moment. It is to, it is to try to determine whether the cot manufacturers were at fault in terms of their manufacture of the mattresses, so it's a rather sensitive issue commercially as well as with the government.

MAM Are you looking any wider for causation or are you just concentrating on this issue to get it out of the way, or maybe incriminate it?

WH The majority of the work is in relationship to that, both, a number of us on the committee however are concerned about some of the wider issues. And there have been two confidential inquiries of cot deaths, national ones; I can't remember the precise names, case control studies of inquiries of cot deaths in three regions of the United Kingdom. These have now been published. I think they have been rather badly presented because they lay all of they lay most of the blame on things like cigarette smoking by the parents. However, they neglect completely that there is an enormous excess of single mothers compared to, in amongst the deaths compared to the controls. They haven't really allowed for that. And the same is true for poverty, so that certainly cot deaths are associated with poverty, single motherhood and all the

social consequences of that, and the study has been poorly done in that it has not really tried to disentangle the relative contributions of these. And that will come out I hope in the final report.

MAM It's quite likely that that committee anyway, even if your mattress story is definitive, will actually go on because it's obviously something in the public mind?

WH Yes, yes.

MAM I'm sorry, I interrupted you. Now, your second…

WH The second one is, I suppose, I've taken on the chairmanship of the research committee of the Stroke Association which sort of in, now disburses actually quite a lot of money for research on stroke. And we're changing direction slightly in that we've developed a strategy so that we are trying to tackle the unanswered questions rather than only being reactive. We're doing it in this, we're not commissioning research as such, but we're saying we're interested in proposals in certain areas such as, for example, Afro-Caribbeans, such as psychological well-being of young patients with stroke, because these are gaps where we know almost nothing. I suppose the third interesting committee is the Swedes have invited me to chair a committee to review all their epidemiological research, and make suggestions to the Swedish research foundations and research councils as to the groups that should be encouraged and the areas which should be explored further than they are at the moment. That's only just beginning.

MAM Is that an academic epidemiological approach or are they interested in a public health aetiology approach, or are they, is it an omnibus?

WH It's all of it. It is a combination, the, if you like, the denominator of all the groups supported through their medical research council, their social research council, their health services research council or whatever it's called, a cancer foundation, the national environment council and so on. So that it is all of the research group, research funders have got together and said 'We want to, an outside opinion as to where we're going.' Which is quite interesting.

MAM Is there a committee to do that?

WH Yes, there is.

MAM Are the rest Swedes, or…

WH No, there are no Swedes. It's, it's a very interesting, they… This is very much a Scandinavian or Nordic model in that on an inquiry like this they ask the opinions of outsiders who really have no axe to grind. The others on the committee are: from this country Nick Day who is professor of public health in Cambridge, and a statistician – Malcolm Harrington – who is a professor of occupational medicine on health in Birmingham; from the Netherlands, Albert Hoffman who is a clinical epidemiologist, Louise Gunning-Schepers who is an economist; and from Denmark, a man called Jøm Olsen who is professor of epidemiology and public health at the University of Århus.

MAM That's quite a major task, that's actually…

WH Yes, it is. Letters have gone out to all the groups as to what data we want, I go to Sweden next week and divide up the work between the six members of the committee, and we then meet in April and again in May to review our findings and discuss it with the Swedes.

MAM I say that because you're not only putting together the national picture of what's going on and what's being done. But if you're advising on future policies, then you have also actually to look at the other work in other countries to give a priority, which is an enormous task.

WH Yes.

MAM So that's going to keep you fairly busy in retirement?

WH Yes.

MAM Now, I know that you had two areas of work that you were starting before you retired, but I understand that you are, in fact know that you're carrying them forward now. And they are both of interest, and we didn't touch on them in the talk we had taking you up to retirement, although they both started before. And I wondered – to complete the picture – if we could talk about those two areas and start with something that's become very important recently, which is the health of doctors?

WH Yes. Well, I mean I think our attention was drawn through a variety of means both from Nuffield Trust(?) and others that there were problems with the, both the health services and the health of doctors. What we did was, we have so far done three bits. The first stage was essentially an anecdotal study in which we went to eight districts in the United [Kingdom], in England. The districts were chosen in that four of them were districts with the highest mortality ratios for suicide amongst doctors, and there were four districts that were matched in terms of their characteristics such as urban, rural, teaching or non-teaching. It was an attempt to have a, not to have a proper random sample but at least to base it on a certain hypothesis which is that there would be differences between areas with a high mortality rate, or suicide rate compared to areas with a low. In each district we interviewed about twelve senior individuals – people like the director of public health, the chairman of medical staff, the president of the junior doctors mess, the chairman of the local medical, the GP chairman of the local medical committee and so on. So we interviewed about twelve senior individuals in each district to find out something about the health services that were provided <u>for</u> doctors and the attitude towards them in their district, also what use is made of them and so on. To our surprise, we found there was no difference between the districts, whether they had a high or low mortality rate, they were equally bad in all of them.

MAM Bad in the sense of the services?

WH Bad, they were… The services provided for doctors were appalling. The, few if any of the junior doctors had a general practitioner or were registered with a general

practitioner. There was no uniform way whereby they could approach anybody about their own problems of ill-health or anything else. In some areas, the so-called committees of the three wise men, which are supposed to supervise the problems of mental health or mental performance and so on, were non-existent. In some of them they, nobody knew which, whether, who was a member or not. And in one district we even discovered that the chairman and the members refused to discuss what they did with us because they said it was entirely confidential. Occupational health services which are supposed to exist obviously were present, but they were viewed with very great suspicion by the doctors because they were, the doctors felt that they weren't confidential enough. The real problems were amongst the GPs and amongst the juniors. The anecdotes that we heard were quite horrendous such as, for example, one patient saying to a doctor 'But you're iller than I am, you should be in this bed, not me.' So that they really were not very good. As a result of that, we then did a second study. In that study, we took three districts and we did a questionnaire approach to all doctors employed in those districts – that is both general practitioners, junior doctors and senior doctors. And we took a control group, that is we took a group of individuals that we thought were of an approximately equal … status in terms of what they did. We took managers; individuals employed in a large management accountant consultancy firm. What we found was that the levels of health of the two groups were very similar, that is the doctors in general were perfectly fit as were the management consultants. The number of episodes of illness between the two groups was not all that different. However, the way in which they used medical services if they were ill were very different, in that the doctors rarely took time off work compared to the management consultants who took time off work when they were ill. The doctors felt that they couldn't take time off work because either their friends would have to cover for them and they were already under enough pressure, or they'd be letting down their patients, or they felt that they could cope even though they were ill. So that when they had to take off time, take time off work, the doctors had much longer periods of sickness absence for an episode than the management consultants.

MAM So, the implication is that when eventually, if a doctor finally took time off, he was pretty ill and that illness took actually longer to recover from?

WH Yes. Then we, what we then did was to have some measures of stress. We found that in, in general the doctors were, felt that they were under greater stress than the management consultants, which was interesting. They all felt they were under stress, the doctors felt they were under greater stress. We found the GPs were the ones who were most at stress followed, interestingly enough, by the senior doctors, and...

MAM The consultants?

WH Yes, the consultants, and then the junior doctors, and then the management consultants. That was the rank order.

MAM What was the – you say the GPs were the most stressed, what were the factors that particularly stressed GPs?

WH I think it was a variety of … because first of all they felt that the demands of patients had increased considerably, and had become unreasonable in their views.

Secondly, they felt they were being asked to do things for which they could see little point. And they were particularly concerned about the amount of form filling, about the amount of unnecessary procedures that they had to undergo, and how little control they had over their own lives. The senior doctors felt that their status had gone down, they weren't supported adequately, and if they were ill, there was nobody else to take their place. And the junior doctors felt that they were not, they had very little peer support, and their ability to live in messes had gone, they had poor food at night if they were on duty, their seniors didn't necessarily support them in some instances.

MAM So, we're saying something different between the GPs, and the hospital doctors. The hospital doctors from what you were saying was more a change in professional practice was causing stress, whereas with GPs it was the change in patients and management requirements of accounting etc.?

WH Correct, yes, yes. Then we, in addition to that we invited doctors to come to us with stories of their experiences of illness. And we had about sixty to eighty interviews in depth with individual doctors who recounted to us quite openly but unattributably their experiences of illness so that we had a better appreciation of the problems that doctors face when they are ill, and the problems are ... many-fold. For example, they don't necessarily get any support from their superiors if they are ill, or their partners. Their partners feel that they are shirking. They don't necessarily get as good care as the lay-patient because the consultant or the carer, the caring doctor feels they ought to know what is wrong with them. That or they don't, it's not explained to them, and things are not done as well as they should be. There is also the question of delay in seeking help and seeking treatment because they feel that they will be able to 'tough it out' or be able to look after themselves. So, all these things add up to inadequate health services for the medical profession.

MAM Of that group taking the two studies, have we any idea of, did you illicit any idea of, firstly, what percentage of all the doctors appeared to be dangerously stressed, not dangerous in themselves but possibly not able to do clinical medicine to an appropriate standard? And are we talking about a very small problem as far as the patient's concerned or is it actually quite a significant problem?

WH I suppose the, I mean, it is very difficult for me to answer that question because remember we only looked at about five hundred/six hundred GPs and five to six hundred consultants, and about three or four hundred junior doctors.

MAM It's quite a significant number.

WH I would not think that... Yes, all right. Probably around 1 to 2 per cent, but it's very difficult to...

MAM So, there'd be 1 to 2 per cent of people who really oughtn't to be practising medicine in their state, and presumably a lot of other people who are, are not as good as they should be?

WH Well, yes, I would agree with that completely. Perhaps there is some, I mean I think that the figures that... Other people have done some studies which make the figures even more frightening. I've recently seen a study which was done on about 17

to 18, I'm sorry, 12,000 people employed within hospitals by a group of psychologists in Sheffield and Leeds, who find, using a standard method of inquiry which was used on the general population as well, they classify NHS personnel, 28 per cent of NHS personnel to be under stress and psychiatrically abnormal, and what they call 'caseness', compared to a general population figure of 18 per cent. The two groups who are at highest level of this are women doctors where it is 49 per cent, and women managers where it is at the same level of 49 per cent, which is a frightening, is a frightening... You can question, I mean you can argue that the criteria used are too broad, too sensitive or pick up too many cases. But nonetheless its the same instrument is used on the general population, general employed population for the same age, and it's less than a third or less than a half of the total population that show these abnormalities.

MAM By any standards they're, those are bad figures, aren't they?

WH Yes.

MAM They're bad for clinical medicine, but they are also bad because they must surely be leading in the long run to people, where they can, leaving the profession?

WH Yes, the... Obviously that is the next point which is that we can't really get the figures, unfortunately. The figures that are available show that doctors, the proportion of doctors, the proportion of doctors who take early retirement on health grounds has increased every year since about '91/'92, by about 10 to 14 per cent. Unfortunately, it is not possible, for reasons that... I am unable to determine – they won't tell me – why it is, what the reasons are or what the causes are and so on, but it is frightening that we are losing that proportion of doctors early.

MAM Yes, because there is significant cost to train, and we're not getting our money's worth, if you like, as taxpayers

WH Yes, yes.

MAM Now, I think you mentioned you'd done three studies?

WH I did. The third study was then to try to determine... We put forward certain ways that we thought the problem could be tackled. The first was to have a designated individual doctor in each district to whom the sick doctor could turn for advice as to where to go.

MAM Would he be...

WH A senior...

MAM ...but more or less dedicated to that job?

WH Yes, we would hope that he would be dedicated to that post. Secondly, we felt that it was essential that if you sought, if you needed in-patient care, that it should not be provided unless you wanted it provided within your own hospital or district. This is particularly important for cases of psychiatric illness, alcohol, drug dependence and

so on. Thirdly, we felt that it was very important actually to be concerned with prevention. And we thought that it was important that there should be an independent mechanism within each region and district which would try to promote better conditions for the doctors, such as for example the provision of adequate locum services, the ability to have proper meals at night if you are on duty at night, the ability to call for help if you needed it, proper education facilities and so on. And we thought that the, that this could best be done through a small group within each place that was empowered to, if you like, inspect and review what was going on, but then also to publish annually both whether their criteria would be met or not and what the inadequacies were. So that in fact if there were deficiencies that they would be made public. And the third study was really to discuss this with three districts, in depth, and try to see whether they would feel that this was acceptable or whether they thought that it was a waste of time. The response to that was in the main they thought it was a good idea. They felt that, in one district certainly they felt that occupational health services might be capable of doing a part of it, but it was not there at the moment, so it was not... And they also felt that theoretically the structure for junior doctors, for example, was there through the regional review committees of junior hospital staffs, but it had been abolished, so that they felt that these suggestions which were put forward through a working party of the Nuffield Provincial Hospitals Trust were a workable set of conditions and should be introduced.

MAM One can see that the, one of the particular problems of the stress factor is letting your colleagues down, so you go on working. And the provision of adequate locums so that you don't have to worry about letting your colleagues down is a very difficult one, isn't it, because it means posting someone in not next week but within 24 hours, with that, you know, feeling that I'm letting people down... And the same with GPs. And that may be that you almost need a pool, don't you? I can see in hospitals, you know, that you might have a floating registrar...

WH Well, indeed, the best examples are actually in general practice. There <u>are</u> one or two districts that are introducing this and are also willing to pay for the locums, because one of the problems in general practice of course is that if you call in a locum, it comes out of your own earnings. But in fact some districts are experimenting with the provision of locum cover in order to help the GPs whom they recognised as being the ones under the greatest stress.

MAM You've still got to have a pool to get the chap in quickly, that's going to be an organisational problem?

WH Yes, that's a... Yes, we didn't go into the organising of it.

MAM Are you doing or have you done more work, or are those three studies being reviewed and thought about?

WH Well, we, that's all that we've done. We would like to. We feel that all our studies have been based on, although you say they're large samples, with the frequency then they're actually very small samples. They're also by no means representative. We would like to, if at all possible, to do some national studies using the database for example of the GMC [General Medical Council], in which we would focus on certain occupational groups that already from our studies we feel are in

particular risk, to really determine whether our conclusions on the selected samples are correct and to get a proper view. Precisely what I can't say is whether it is one per cent, half a per cent or ten per cent.

MAM Are you, that would be a national questionnaire...

WH That would be a national... Yes.

MAM ...study with samples of interviews? Are you convinced, because I've, listening to you I would feel you are, that this is not only a genuine problem, but one of real importance to medical manpower in this country?

WH I have absolutely no doubt about it. It costs, I know, between £200,000 and £250,000 a year to train a doctor. And it seems to me horrendous if we put out, say, 4000 doctors which is £800 million, that we actually waste perhaps 5 to 10 to 15 per cent of that through loss from the profession, to say nothing of the danger that this causes to patients who may need help.

MAM Yes. Do we have any knowledge as to whether the government take the same view?

WH I have tried, I am on the wider health working group, which is supposed to advise the Secretary of State on health of the nation. And the wider health working group has one of its... One of the targets is – of the health of the nation – is mental health, and the working group has recently put out a great deal of advice upon how to improve the mental health of the population. I suggested to the, to the secretary, to the minister that perhaps we ought to as well focus on the health of those employed within the NHS. And I'm afraid that she was very taken aback by the figures that I gave her of the frequency of illness and the problems that were faced by doctors. The chief medical officer when asked to comment said my figures were absolutely correct. However, the Department as well as many others felt that through the development of occupational health services the problem would be tackled and the words that were used were 'eventually', so that I'm afraid I have doubts about the degree of urgency by the Department.

MAM I was going to say, it doesn't sound a very immediate action. Now, there was also one other thing that you were doing in retirement, the sick doctors is carrying over, but I believe you've got a fellowship from the Nuffield Trust. Is that right?

WH Yes. The Nuffield Trust has very kindly given me the resources to do a study on the development of public health in this country between 1918 and now, and I have been ... preparing a history of the development of, of this at this time.[1]

MAM That's quite a major job in background?

WH Yes, it's extremely interesting. At the present moment, I have, I've said I'm not doing any more reading. I've read enough!

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[1] This has now been published: Walter W Holland, Susie Stewart, *Public Health. The Vision and the Challenge*, London: The Nuffield Trust, 1998.

MAM You've done all the background...

WH I've done all of that. What I've done is I've read quite a lot of papers, annual reports and what have you. I've also interviewed a number of people, like Sir George Godber, Professor Morris[2] and a number of MOHs [Medical Officers of Health?] and so on to get some feel of it. And there are some extremely interesting things that I'm finding out such as, for example, how rationing, the introduction of, with the First World War, the Second World War was probably one of the major reasons why health improved in this country.

MAM Well, it's always been said, but it is actually true, is it?

WH Yes, yes. Very interesting how ... the knowledge had been present, had been present for about 5 to 10 years, but it was only the war that enabled it to be put into effect. It's interesting how people like Chamberlain[3] were interested in health improvement. And he, for example, refused to become chancellor of the exchequer in 1925, but preferred to become minister of health, and that was I think largely because he would have responsibility for housing, or re-housing, and that was the major problem. And he was very much in favour of decentralisation and local government and he wanted to take the power of the public health authority away from the central Poor Law administration and give it to local government. And so he became minister of health and he was able to promote both these activities as a result.

MAM Though of course he is remembered always for something quite different?

WH Yes, which is very unfortunate because he was very effective in both of these.

MAM Has – the book yet has to be written and published, but are you finding that public health has weakened or strengthened over time? You know, did war improve medical public health or... I mean we are talking about public health medicine?

WH Yes. I think it's very difficult, I think it's very interesting that every ten years or so there is a diatribe that we are all going downhill and then, then it goes up again. It's very interesting that, how it has ebbed and waned and how different, different events have led to a resurgence of interest in the subject and other events have led to, if you like, the prediction of its demise. I think that we are, my hypothesis was that the transfer of hospitals to local authorities and the need for medical officers of health to become concerned with hospital management or, if you like, clinical management...

MAM That would be pre-World War Two?

WH ....1930, yes, actually was bad and led to problems which have beset public health ever since. The problem is that public health becomes, has become, easily becomes enamoured by holding budgets. Many public health practitioners feel that their power lies through having lots of money at their disposal. When they controlled hospitals, they were commanding large budgets. Now, some of them are very much involved in the purchasing of clinical services, not health services, and I think that they feel this is, gives them power and authority. I think there are many others who

[2] Professor Jerry Morris
[3] Neville Chamberlain

feel that their major role is in the improvement of health, rather than only in the purchasing of clinical services. And I think that my hypothesis has been strengthened from what I've read, that unless we become concerned with services which improve health, rather than only with clinical services, we will continue to become, to be second-rate. And that's really my major message. It is perfectly feasible within the present structure to be concerned with, if you like, the contracting or commissioning of services for health which take into account both preventive, curative and rehabilitative services, and thereby to really fulfill what I think is our goal which is the improvement of the health of the public rather than only the health of ill people.

MAM It's, this is purely a view, it strikes me that if you are involved in purchasing and advising on the purchase of health services, which tends to be the way that public health consultants have gone, it tends to be short-termism. Because there is no budget if you like for the long-termism, and short-termism is actually quite easy. But looking much further ahead... Which I think, it is probably the same thing as you are saying, the public health and measures to promote that rather than the health services?

WH Yes. I would, I think that the structure that we have with its concentration, with its clear statement that we are concerned with what is known as the health of the nation does enable one actually to become concerned with long-term goals. That is, we can be concerned about if you like the improvement of health rather than only the short-term response to the current crisis on cardiac surgery or something like that.

MAM But there is a danger it seems to me that if you get caught up with today's purchasing, that actually...

WH Correct.

MAM ...it becomes, it skewers your thinking, if you like, and you become more and more involved in, particularly in the present time of cuts, how do you distribute budgets and what's more important. You lose your eye, if you like, from someone who in the old MOH days was thinking about the health of a population.

WH Yes, I mean I think you are absolutely right and that is one of the difficulties is that today's outbreak is always greater news than in fact something else. I mean, we get, we get very concerned about three deaths from meningitis or five deaths from E. coli 157 or whatever the latest crisis, we don't get concerned about the 6000 road accidents or the 100,000 deaths from coronary heart disease and so on which are probably as important.

MAM Yes!

WH And I mean, I think what public health has to be able, has to be able to do is to balance...

MAM Those two?

WH Those two.

MAM But it may be very difficult to balance them if you have people employed

really thinking and advising about short-termism, that's what I was…

WH Yes, I mean I put forward … some years ago the concept of an independent public health service which would actually be concerned about the sort of long-term issues, both research, the necessary research for that as well as the advice as to what services should be provided and how it should be done.

MAM The last question – when is this book going to be published?

WH I hope…

MAM Next year?

WH I hope that I will be able to deliver the manuscript to the Nuffield Trust by Easter.

MAM Oh, I see. So, I mean, you've done all, you've started, obviously on that time-scale you've started writing?

WH Oh yes, we're on chapter, we are on chapter three.

MAM Right. That's good. Well, thank you very much. I think anyone who has looked as we have in the last hours or so at your career will not be in the least surprised that retirement is fairly busy to say the least. May it continue. Thank you very much indeed.

WH Thank you.